

Division of Workers' Compensation  
Cover sheet for  
HCO Material Modification Request

**Name of HCO** \_\_\_\_\_

**Date** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_

**Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_

**E-mail** \_\_\_\_\_

**Contact person** \_\_\_\_\_

Please give a short summary of the type of the proposed changes in the space provided below and place a check mark against the box that reflects the proposed change.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Service Area expansion

☐

Change of Materials

Enrollment Form

☐

HCO Brochure

☐

Marketing Material

☐

Web Page

☐

Other (Specify)

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Change of Key Personnel

☐

Change of Org Chart

☐

Change of Contract

Provider Contract

☐

Payer Contract

☐

Change In Network

(Change in 10% or more in Provider Network requires a material modification and change on Provider Directory. )

Change in Ownership

☐

Other (please describe)

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